



## EDITORIAL

## VIOLENCE IN THE WORLD AND IN SOUTH AFRICA — WHAT IS A DOCTOR TO DO?

The WHO *World Report on Violence and Mental Health*<sup>1</sup> aims to raise awareness of the public health aspects of violence and to show how a public health approach can be useful in understanding and responding to violence. More specific goals of the *Report* include describing the magnitude and impact of violence cross-nationally, summarising information on risk factors, prevention approaches and policy responses, and making recommendations for future action and research.

These are indeed laudable goals, and the report may well serve as a platform from which to launch violence prevention initiatives. Importantly, it emphasises science, noting the value of epidemiological surveillance and of evidence-based interventions. The document is comprehensive, and includes chapters on youth violence, child abuse and neglect, violence by intimate partners, abuse of the elderly, sexual violence, self-directed violence, and collective violence.

Many countries, including several African ones, remain characterised by war, prolonged conflicts or state repression, and consequent ubiquitous levels of violence.<sup>2</sup> South Africa is fortunate to have escaped such a fate. Nevertheless, trauma exposure and its sequelae are endemic here not only in high-risk groups such as survivors of past gross human rights violations<sup>3</sup> and the military,<sup>4</sup> but in ordinary adults<sup>5</sup> and youth.<sup>6</sup> Consequently, these phenomena are all too frequent in both primary practices<sup>7</sup> and hospital settings.<sup>8</sup>

Mechanisms underlying such violence are complex, and risk factors range from individual characteristics, through family and community relationships, and on to broad cultural and societal variables. Similarly, a range of interventions is needed in order to address risk factors, and so help prevent violence. An important message of the report, however, is that risk factors can be reliably identified, and appropriate measures taken — violence is not inevitable.

While a public health perspective on violence is clearly important, success depends on several additional factors. Of particular importance, political will is required to encourage initiatives to reduce violence and research to help determine their efficacy. Our own Department of Health is certainly aware of the public health perspective on violence, and has produced sophisticated policy documents. Translating such awareness into successful action is another matter entirely.

Furthermore, public health measures are only as good as the science on which they rest. Although advances have certainly

been made, our understanding of the factors that promote violence, and of the interventions necessary to reduce violence, remains incomplete. The psychobiology of impulsive-aggression and of self-directed violence (suicide, self-mutilation), and clinical trials for patients with these symptoms, are relatively under-resourced but potentially promising areas for further investigation.<sup>9</sup>

Biological perspectives can shed light not only on the proximal mechanisms underlying violence but also on more distal ones. A comprehensive understanding of medical symptoms (e.g. fever) requires investigation of immediate underpinnings (e.g. release of pyrogens) and of evolutionary origins (e.g. adaptive advantages of fever).<sup>10</sup> A growing literature has provided a sophisticated evolutionary perspective that sheds light on variations in the risk of violence as a function of age, gender, and other characteristics of those involved.<sup>11,12</sup>

Readers of this journal may also raise the question whether a public health perspective is relevant to their own practices. What can the individual medical practitioner do about the pandemic of violence in South Africa?

First, medical practitioners can make a difference at a macro level. Practitioners can be involved, for example, in media drives such as Soul City and other efforts that aim to change social attitudes, in advocacy to decrease gun availability and other attempts to introduce laws to help reduce violence, and in programmes to improve parenting and conflict resolution.<sup>13</sup> Surveillance studies on the nature and extent of violence<sup>14,15</sup> need to be continued and extended. In our dual role as professionals and citizens, we can be particularly effective participants in consumer advocacy to prevent violence and increase resources for trauma survivors.

Second, medical practitioners can screen for violence victimisation and perpetration in patients and communities. Exploration of suicidal and homicidal ideation is of course a key aspect of mental status evaluation. Although some have criticised the implementation of screening programmes for domestic violence,<sup>16</sup> we found that South African general practitioners were impressed by how useful such screening was.<sup>5</sup> Similarly, practitioners should routinely screen for sequelae of trauma, such as post-traumatic stress disorder.<sup>7</sup> Hospital administrators and others can and should develop programmes to address trauma and its sequelae.

Third, medical practitioners can make an important contribution to violence reduction by offering appropriate treatments. Substance use, for example, is a key risk factor for violence perpetration (including all forms of interpersonal violence as well as suicide), and can be successfully treated by primary care doctors. Depression is an important risk factor for self-directed violence, and responds well to modern pharmacotherapeutic and psychotherapeutic interventions. Post-traumatic stress disorder, a consequence of and risk factor





for violence, is today eminently treatable.<sup>17</sup> Unfortunately, such conditions continue to be underdiagnosed and undertreated.<sup>7</sup>

Efforts to reduce violence are intimately bound up with the goals of poverty reduction and sustainable development, including improved education, creation of employment, and empowerment of women.<sup>18,21</sup> In this way, violence prevention also parallels public health efforts to contain the HIV/AIDS epidemic. South Africa, including its medical practitioners, has certainly made progress along the road of sustainable development, but the journey ahead remains a challenging one.

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## TRAINING FOR TRAUMA

Trauma is second only to cardiovascular disease as the largest cause of overall deaths in South Africa. Approximately one-third of patients seen in our emergency units present with injuries — interpersonal violence, and the combination of motor vehicles and alcohol, are the main contributors. In a typical American emergency unit, trauma patients make up about 12% of the patient population, while in the UK the figure is about 8%. South Africa is the 'trauma capital' of the world, and some overseas doctors spend time in our hospitals to gain experience in the management of traumatic conditions.

The Global Burden of Disease study<sup>1</sup> found that injuries were responsible for 10% of overall deaths in 1990, and that by the year 2020 there would be 'a decrease in death from infectious diseases and perinatal disorders and increases in deaths from motor vehicle accidents, violence and war'.

To manage the extent and nature of the trauma we see in our country effectively, training is required at several levels, and for a variety of health care professionals. Our 'pre-hospital' emergency medical services are short of paramedics (advanced qualification). Frequently senior paramedics find themselves behind a desk in an administrative role, while personnel with intermediate and basic qualifications 'man' the ambulances.

The shortage of nursing staff has become a greater problem than before, partly because fewer people are entering the profession. Careers for both paramedics and nurses should be made more attractive by improving working conditions and pay — if this is not done we will not have people to train in these fundamentally important disciplines. Those offering training to these two groups of health care professions have a huge responsibility in making their courses relevant, interesting and of an international standard. There are three recognised post-basic training programmes for nurses that are relevant to trauma: the Rand Afrikaans University's 1-year trauma course, the University of the Free State's 1-year course in trauma/emergency nursing, and the 6-month emergency nursing course offered by Technicon Southern Africa.

Only 2% of patients attending tertiary hospital trauma units need such a facility.<sup>2</sup> The vast majority of trauma cases can be treated at level two and level three emergency units, i.e. secondary hospitals, district hospitals and private emergency units, provided that these facilities are geared towards the delivery of 'first-line' emergency care, which of course includes adequately trained nursing and medical staff.

Only a minority of medical practitioners are adequately trained to deal with the conditions with which they are presented in our emergency units. In spite of the ATLS (Advanced Trauma Life Support) course which has been offered by the Trauma Society of South Africa since 1992, there has to date been no minimum training requirement set for the

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